ILLINOIS ACADEMY OF FAMILY PHYSICIANS

MEMORANDUM

TO: **The Illinois Health Care Reform Implementation Council**

FROM: **Illinois Academy of Family Physicians**

RE: **Health Insurance Exchange considerations for Illinois**

DATE: **December 1, 2010**

The Illinois Academy of Family Physicians hopes the creation of a health insurance exchange will give Illinois the opportunity to move from a volume-based to a value-based health care system by putting in place measures to better reward the provision of primary care services.We believe exchanges represent an opportunity to make an investment in primary care. And we're not alone: Helen Darling, president of the National Business Group on Health, said that the exchanges could serve as a "force for transformation in the health care system," one that could lead to a primary care-based system."If we take overuse, waste and inappropriate non-evidence-based medicine out of the health care system, we will have a lot more money to pay for all of the things we have already committed to pay for," said Darling. "We shouldn't waste this moment."

Furthermore, Gerry Shea at the AFL-CIO, said a patient's experience with the health care system often is determined by access to a good primary care setting."First of all, we have to give people primary care coverage," he noted. "But secondly, we have to think of ways to make the primary care situation as good as it possibly can be."

Much of Illinois' challenge will be in how the health care plans within the exchanges construct their networks. In our opinion, the networks will have to:

- require that participating plans provide access to team-based, coordinated primary health care if they are to successfully improve outcomes, address health care disparities and bend the cost curve.
- make health insurance work for the sick as well as the healthy
- address health care disparities by providing adequate access to primary care
- pay more and differently for primary care services by moving away from fee-for-service to a system that rewards care coordination and value,

According to Jon Kingsdale, Ph.D., an expert on the Massachusetts Commonwealth Health Insurance Connector Authority, known as "the Connector," which was established in 2006, an exchange needs to address the following goals:

- Facilitate comparison shopping
- Reduce administrative costs
- Enhance price competition among health plans
- Transition safety-net providers
- Transform healthcare delivery

Dr. Kingsdale also reviewed lessons learned in the Massachusetts exchange experience to date:

- "It's a campaign"
- Research and experiment
- Communicate, communicate, communicate
- Huge technology challenge/opportunity
- Outsource, partner and collaborate
- Simplify and standardize
- Consolidate legacy programs, if possible
- Consider new exchange "applications"
- Rationalize program eligibility
- Reform healthcare delivery, too

Our national organization, the American Academy of Family Physicians, compiled the following state examples. Of note are the guiding principles in Connecticut, Pennsylvania, and Wisconsin. Similarly, learning from the mistakes of failed exchanges is crucial: a list of those is also included.

Twenty-six states have laws that explicitly permit health insurance purchasing arrangements: Arkansas, California, Colorado, Connecticut, Florida, Georgia, Illinois, Iowa, Maine, Massachusetts, Minnesota, Mississippi, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, and Wisconsin. However, not all of these states have taken an active role in establishing exchanges.

States with Established Health Exchanges

Massachusetts - The Commonwealth Health Insurance Connector Authority, known as "the Connector," was established in 2006 when the state legislature passed system-wide health care reform legislation, which included a mandate that most residents be insured. The state provided the exchange with an initial $25 million appropriation with the expectation that it will become self-sustaining through retention of premiums.The Connector is an independent public entity with a board of directors whose members include state officials and appointees of the governor and attorney general.

Through the Connector, individuals with incomes up to 300 percent of the federal poverty level, not eligible for Medicaid or Medicare, and, who do not have access to employer-sponsored insurance, can enroll in plans with premiums based on a sliding income scale. The Connector also provides access to health plans that employers with fewer than 50 employees can purchase, and in which higher-income individuals without an employer-sponsored plan can participate.

New Mexico - In 1994, the state legislature passed legislation establishing the New Mexico Health Insurance Alliance to provide increased access to health insurance for small businesses with less than 50 employees and self-employed. The Alliance operates as a nonprofit public corporation and is governed by a board of directors, five of whom carrier members elect and 10 of whom the Governor appoints. All insurance companies covering public employees or retirees in New Mexico are required to participate in the Alliance.

Utah -Following the enactment of state health system reform legislation, HB 133 of 2008 and HB 188 of 2009, the state Office of Consumer Health Services created the Utah Health Exchange, an internet portal designed to electronically connect consumers with information on the cost and quality of available health insurance programs. Companies choose a fixed amount to contribute towards employee health benefits and employees can contribute pre-tax earnings. The intent of this exchange is to make health care costs more predictable for employers and to increase choice and portability of health care plans for consumers. The health exchange initially was available to a limited number of companies in the small group market with between two and 50 employees. As of January 2010, eligibility expanded to all small businesses in the state, and the exchange will begin taking large employers and individuals in 2011.

During the 2010 legislative session, Governor Gary Herbert (R) signed SB 294, which included provisions giving insurance carriers the option to participate in the defined contribution market on the health insurance exchange but prohibiting carriers not participating in the exchange by January 1, 2011 from joining until January 1, 2013. The measure allows insurance carriers to offer defined benefit products in the traditional market outside the exchange only if the same rating and underwriting practices are used, but carriers cannot treat renewing groups—transitioning between the traditional market and the exchange—as new business, subject to premium rate increases. Small employers can select insurance products in the exchange or in the traditional market outside of the exchange, and effective January 1, 2013, a risk adjuster mechanism will be imposed on the small group market inside and outside of the exchange. The bill requires health care providers to supply consumers with information about prices and clarifies the type of information an insurer must submit to the exchange and to the state Insurance Department. The new law also requires the health insurance exchange to: (1) create an advisory board of appointed producers and consumers; (2) establish electronic standards for delivering the uniform application; and (3) appoint an independent actuary to monitor the risk and underwriting practices of carriers to ensure that these practices are the same inside and outside of the exchange. SB 459 also enacted in 2010 requires greater choice of benefit plans for employers in the defined contribution market of the health insurance exchange.

States in the Process of Establishing an Exchange

California - California was the first state to begin establishing an insurance exchange following the enactment of federal health reform. On September 30, 2010, Governor Arnold Schwarzenegger (R) signed two bills into law. SB 900 creates the California Health Benefit Exchange within the state's government and establishes a board—composed of the Secretary of California Health and Human Services and members appointed by the Governor and the Legislature—to govern the exchange. AB 1602 specifies the powers and duties of the board governing the exchange relative to determining eligibility for enrollment in the exchange and arranging for coverage under qualified health plans. The bill also creates the California Health Trust Fund as a continuously appropriated fund and allows for the development of various requirements on participating plans and insurers. California law prohibits the sale of catastrophic plans and requires all participating insurers to offer plans within four levels of benefits both inside and outside the exchange, which should help to minimize adverse selection.

Oregon - HB 2009 of 2009 requires the Oregon Health Policy Board to develop a health insurance exchange to allow comparison-shopping for insurance plans. At an October meeting in 2010, Board members endorsed moving forward with an innovative health insurance exchange to drive health care system change. Board members agreed that a well-designed exchange can improve access to insurance and health care, increase consumers' ability to compare health plans, and support efforts to improve health care delivery in Oregon. The

Board will present recommendations on the structure and governance of the exchange to the legislature in December for discussion in the 2011 session.

Washington - HB 1569 of 2007 established an exchange, the Health Insurance Partnership (HIP), to help small employers offer affordable, reliable health coverage. The Health Insurance Partnership Program Development Report issued January 2009 reported that due to a $5.7 billion budget shortfall forecasted for the state's 2009-2011 Biennium, the Washington State Health Care Authority (HCA) delayed implementation of HIP, not accepting applications for coverage until September 2010 with coverage beginning January 2011. The state was able to continue with the HIP initiative, despite the deficit, after receiving a five-year, $34.7 million federal grant in October 2009 from the State Health Access Program (SHAP) within the Health Resources and Services Administration (HRSA).

According to the office of Governor Christine Gregoire (D), over 1,100 employees of small businesses can enroll in the new program and the state will cover program costs for approximately 650 low-income enrollees. The program is open to employers with 50 or fewer employees, providing them with access to the same health insurance coverage available in the small group health insurance market, but at a significant savings. The employer contribution rate within the exchange is only 40 percent of the cost of coverage, compared to the standard 75 percent in the small group market.

States Considering Establishing a Health Insurance Exchange

Colorado - In April 2010, Governor Bill Ritter (D) issued an executive order creating the Interagency Health Reform Implementation Board to implement health reform in the state. The Board currently hosts community health insurance exchange forums to build shared understanding about exchanges, collect input from wide range of stakeholders on best way to structure exchanges, and gather information to develop a "Stakeholder Perspective" report to inform the efforts of the general assembly and new governor during the 2011 session.

Connecticut - Governor M. Jodi Rell (R) issued an executive order, in April 2010, creating the Health Care Reform Cabinet, comprised of commissioners from various state health agencies. The cabinet is responsible for informing state residents on the effects of PPACA, including insurance exchanges and insurance market reforms. The Cabinet's Insurance Exchange Workgroup issued a report in September indicating that the state received a $996,850 federal grant to beginning planning an insurance exchange. In 2009, the Governor created the Connecticut Health Care Reform Advisory Board to prepare a set of proposed health care policies in response to federal health care reforms. In the Advisory Board's final report issued June 2010, exchange-related recommendations focused on consumer choice, plan competition, innovation, quality of care, and cost-control. The Board recommended Connecticut design an exchange that:

- Focuses on individuals and small employers;
- Contracts with other state or private entities, as appropriate;
- Is administered by a quasi-state authority (similar in structure to the Massachusetts Connector);
- Has a multi-stakeholder Board of Directors; and
- Collaboratively works with state agencies and within the state's regulatory framework to avoid duplication and to enhance interoperability.

Illinois - Governor Pat Quinn's (D) twelfth executive order of 2010 created the Illinois Health Reform Implementation Council and required it to provide recommendations on how the state initially should implement PPACA. The council's first report—due to the Governor Quinn by December 31, 2010—will include directives on how Illinois should establish a health insurance exchange and other related consumer protection reforms.

Maine -In April 2010, Governor John Baldacci (D) issued an executive order creating the Health Reform Implementation Steering Committee, appointing various members of the administration representing the state's health and insurance agencies, and charging the group to immediately develop a plan for the creation of the State Health Exchange and to coordinate efforts with the legislative Joint Select Committee. The Steering Committee presented exchange recommendations to the Joint Select Committee on October 20, proposing that the state create two separate exchanges for small businesses and individuals to operate independently or as a quasi-state agency. Maine also should coordinate such efforts with other New England states.

Minnesota - Governor Pawlenty ultimately enacted legislation concerning the establishment of a health benefits exchange—as part of the global budget agreement, passed on May 17 during the legislature's brief special session. HF 1 included additional reductions in spending of approximately $70 million for state FY 2011. The supplemental budget also included funding and authority for the Governor to apply for early expansion of Medical Assistance for adults without children up to 75 percent FPL.

Mississippi - In January 2008, the Mississippi Center for Public Policy published an issue brief, recommending the legislature establish a statewide health insurance exchange, for which Governor Haley Barbour (R) expressed support in a March 2008 press release. Although legislators introduced several bills during the 2008 and 2009 legislative sessions, the legislature failed to enact legislation on the topic until 2010. Signed by the Governor on April 14, SB 2554 creates a Health Insurance Exchange Study Committee to conduct a study of exchanges as proposed in PPACA and to make implementation recommendations by December 1, 2010.

Nevada - SB 316 of 2009 requires the Legislative Committee on Health Care to consider the establishment of a health insurance exchange to promote options of insurance products. Following this examination during the 2009-2011 interim, the committee will report recommendations to the Legislature. An April 21, 2010 meeting included discussion of the benefits of health insurance exchanges and related IT requirements Nevada needs to consider. Other issues for the state to determine include: (1) the number of exchanges; (2) possible partnerships with other states; and (3) federal government involvement. The Division is required to make substantial progress toward a plan for the health insurance exchange by 2013.

Pennsylvania - In July 2010, Governor Ed Rendell (D) issued an executive order creating the Commonwealth Health Care Reform Implementation Committee and the Commonwealth Health Care Reform Advisory Committee which, in turn created an Exchange Subcommittee. The subcommittee determined that the state must decide (a) if the small business and individual exchanges should be separate, (b) the employee size of small businesses allowed to participate, (c) if those eligible to buy insurance through the exchange should be allowed to buy insurance outside of the exchange, and (d) minimum standards for health plans sold. The subcommittee's guiding principles include that the state's insurance exchange:

- Have strong consumer-oriented mission and goals;
- Is guided by a governing board and a strong executive team;
- Operates as an independent public agency or public corporation;
- Has a statewide scope (rather than separate regional exchanges);

- Serves as an active purchaser of insurance;
- Allows rate reviews by the Insurance Department and requires the same premium rates for plans sold inside and outside the exchange;
- Makes insurance agents/brokers available but holds small businesses responsible for payment;
- Authorizes the state legislature to make changes to benefit requirements; and
- Eventually becomes financially self-sustaining.

Two bills currently under consideration by the Pennsylvania House of Representatives, if enacted, would help to direct the state in implementing a health insurance exchange as required by federal law. HB 2462 would establish the Health Insurance Reform Implementation Authority and the Health Insurance Reform Implementation Authority Fund and eliminate duplication between the state's Department of Public Welfare and the Insurance department to make a variety of programs, including the American Health Benefits Exchange, more efficient. HB 2759 would establish the Pennsylvania Health Insurance Reform Implementation Authority, create a health insurance exchange for the small employer group and the individual markets, and authorize a surcharge on health benefit plans to pay for the Health Insurance Exchange.

Rhode Island - Although legislation introduced during the 2010 legislative session would have established a state exchange, neither HB 7560 nor SB 2552 passed the legislature. Instead, the state Senate passed a resolution (S 3021), in June 2010, to create a special Senate Commission to study cost containment, efficiency, and transparency in the delivery of quality patient care. The resolution specifically authorizes the commission to study the development and establishment of a state-based health insurance exchange as provided in PPACA.

Vermont - In May 2010, Governor Jim Douglas (R) allowed SB 88 to become law without his signature, stating he supports cost-containing provisions but does not approve of the bill because the state cannot pursue certain plans until 2017 as required by federal law. The new Vermont law charges the Health Care Reform Commission with proposing as many as three design options for creating a single system of health care in the state, one of which must be a government-administered and publicly financed single-payer benefits system. Included in the report, due February 1, 2011, must be a comparative analysis on the new federal insurance exchange, as well as a proposal for the state to participate in an exchange established by PPACA. Posted on the state's Health Care Reform webpage are the abstract, project narrative, and workplan for Vermont's HHS State Insurance Exchange Grant Application. Under the grant, Vermont proposed to:

- Analyze the current insurance market to determine the quality and type of health insurance coverage, the appropriate regulatory environment for implementing the exchange, and the potential impacts on the market of various options;
- Assess various exchange organizational models and the policy and fiscal implications of each, as well as resources needed to operate the exchange;
- Model potential funding mechanisms to achieve exchange sustainability; and
- Develop proposed legislation for the 2011 and 2012 sessions.

HHS awarded Vermont the full $1 million available to create an American Health Benefit Exchange.

Virginia - On May 14, 2010, the Virginia Secretary of Health and Human Resources announced the establishment of the Health Care Reform Initiative to manage activities related to federal health care reform. Serving as the liaison between the governor's office, agencies and entities affected by health care reform, the

initiative will lead development of the required health insurance exchange, as well as identify and coordinate grants to fund such efforts. The initiative—charged with reporting recommendations to the governor—scheduled meetings throughout 2010.

Wisconsin

Governor Jim Doyle (D) issued Executive Order #312 in April 2010 to create the Office of Health Care Reform led by the Secretary of the state Department of Health Services and the Commissioner of Insurance. The office is responsible for developing a plan that uses national health reform to build on the state's existing programs. The office also is to assess insurance markets reforms to prepare for national health reform, develop a plan to pursue federal funding for implementation, and create a health insurance purchasing exchange. Posted on the Office's website are the Guiding Principles for the WisconsinExchange:

- **Keep It Simple** – one single website for everyone with concise, easy to understand information about pricing, benefit plans and options;
- **Bring about Real Change** – make the Wisconsin exchange a vehicle to expand coverage, lower prices, and change the way we pay for health care in our state;
- **Build off Regional Strengths** – Wisconsin has the benefit of strong regional hospitals and insurance providers;
- **Focus on Customer Service** – the website must be easy to use, and community partners and insurance brokers should help consumers make informed decisions; and
- **Coordinate with Existing Health Care Reform Efforts** – take advantage of efforts already underway and seek to not duplicate work.

Examples of Failed Exchanges

California's PacAdvantage- Established in 1993 by the state legislature as Health Insurance Plan of California (HIPC) with a government loan of $5.5 million.Governed by the Managed Risk Medical Insurance Board, a government agency in the Health and Welfare Agency.Offered health insurance plans to small businesses of two to 50 employees throughout California. Negotiated premium prices with potential health plans and could elect to not include unsatisfactory plans. Privatized in 1999 by legislature, changing name to PacAdvantage.Closed in 2006. Despite efforts by Governor Schwarzenegger and state legislators until 2008, the state was not able to form another exchange. An issue brief released by the California HealthCare Foundation in July 2009 attributes the failure to not being the exclusive source of coverage for that population

Florida's Community Health Purchasing Alliances -State legislature established 11 alliances throughout the state in 1993. Enrollment available for self-employed and small employers with up to 50 employees.Initial funding provided by state but after several years the alliance was expected to be self-financing. Enrollment peaked at 92,000 in 1998. Faced resistance from insurance brokers, who made low commissions.Closed in 2000; insurers withdrew from the program due to an inability to help small businesses pool resources effectively.

North Carolina's Carolinance- State legislature established six alliances in 1993, providing $6 million initially. Each had a governing board of local small-business owners, an executive director, support staff, and a third-party administrator. Enrollment peaked at 4,300 in 1995. Closed in the late 1990s because healthy groups purchased less expensive policies outside of the exchange.

Texas Insurance Purchasing Alliance - State legislature established in 1993 as pilot in Houston and expanded to statewide in 1995. Modeled after California HIPC but organized as a private non-profit corporation, rather than a governmental entity. Offered coverage to small employers with 3 to 50 employees.Administered by a participating health plan, Blue Cross and Blue Shield of Texas.More than 20 health plans participated at some point. Peak enrollment was about 1,000 firms with 13,000 people total. Closed July 1999 as it could not remain competitive with policies offered outside of the alliance.

Concluding Remarks

The Illinois Academy of Family Physicians offers its support for establishing an Illinois health insurance exchange, but cautions against any attempt that would slight coverage of primary care services. We welcome the opportunity to collaborate, simplify and standardize the process in order to improve patient health and access to quality healthcare coverage.

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Founded in 1947, the Illinois Academy of Family Physicians represents more than 3,500 family physicians, family medicine residents and medical students dedicated to excellence in family medicine and the patients they serve. Visit www.iafp.comfor more information.